



TennCare Specialty Pharmacy Network Participation Application

INSTRUCTIONS: PLEASE COMPLETE ALL INFORMATION. YOU MAY ATTACH ADDITIONAL SHEETS AS NECESSARY. INCOMPLETE SUBMISSIONS WILL NOT BE PROCESSED.

GENERAL INFORMATION

Pharmacy Name: _____		NCPDP#: _____	NPI: _____
Tax ID#: _____	DEA#: _____	State License#: _____	
Address: _____			
City:	State	Zip Code	
Phone#: _____	Fax#: _____	Email Address: _____	
Name of Person Who Signs Third Party Contracts: _____			

PHARMACY INFORMATION

Describe your pharmacy's organizational structure, including names and titles of relevant parties:
Please provide the name and state license# of the pharmacist in charge for your pharmacy.
Has your pharmacy ever filed for bankruptcy, receivership, or reorganization? Yes ___ No ___ List your pharmacy's patient services and indicate the approximate amount (%) of business you do in each (i.e. retail, mail service, long term care, specialty, compounding, IV infusion, internet, other)
What is the average number of prescriptions filled per week? _____ per month? _____ Hours of Pharmacy Operation: M-F: _____ Sat: _____ Sun _____ HOL _____ List the names and addresses of your disaster recovery location(s):

SUPPLY CHAIN INFORMATION (Complete if shipping specialty medications)

What is the name of your primary shipping company? _____

How many hours do your packages maintain their temperature integrity? _____

How was this verified? _____

How do you document your turnaround time for orders (% orders received by need-by date)?

CUSTOMER SERVICE

Hours of Customer Service:

Hours of Operation: M-F: _____ Sat: _____ Sun. _____ HOL _____

Phone# (if different than above): _____

Name of Hearing/Speech Provider:

Hours of Operation: M-F: _____ Sat: _____ Sun. _____ HOL _____

Phone/Access# _____

What is the phone number that the member uses to access to a pharmacist 24/7/365? _____

How do you document your average speed of answer for telephone calls?

How do you document your call abandon rate?

SERVICE/ PROCESS INFORMATION**How do you document your pharmacy's overall accuracy rate?****Describe your pharmacy's quality improvement process:****Please list the different mediums that are used to provide education to the patient. Attach examples.****What are your pharmacists' and nurses' roles and responsibilities? How are they involved with patient care?****Please describe your pharmacy's clinical programs for (include operational flow charts as appropriate):****What are your pharmacy's criteria for determining if a patient is noncompliant?****What is the process for communicating this to the patients/providers?****How do you track and document patient compliance rates?****Name of Person Completing This Form:**

SIGNATURE

DATE